

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2497

CERTIFICATE OF DEATH

Reg. Dist. No. 02486

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newark, Worcester</i>		c. LENGTH OF STAY IN 1b <i>3 mo 4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		First	Middle
		<i>l</i>	<i>Brittingham</i>
4. DATE OF DEATH <i>Jul 20 1959</i>		Month	Day
		Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <i>Aug. 15-1877</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe Store</i>	
10c. BIRTHPLACE (State or foreign country) <i>Berlin, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>Mathias Brittingham</i>		14. MOTHER'S MOTHER'S NAME <i>Mary Jarman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Delta B. Jarman</i>		Address <i>Snow Hill, MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>480.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arterosclerotic Heart Disease</i>			
(c)		2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary Emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>September 1959</i> to <i>February 1959</i> , that I last saw the deceased alive on <i>Feb. 20, 1959</i> , and that death occurred at <i>9 P. M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John M. Bender</i> M.D. <i>104 Bay St. Snow Hill, Md.</i> PHYSICIAN'S NAME (Type) <i>John M. Bender</i> <i>104 Bay St. Snow Hill, Md.</i>		ADDRESS (Street, city or town, state) <i></i> DATE SIGNED <i></i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jul 23/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Riverside Cemetery</i>	
22d. DATE THEREOF <i>Jul 23/59</i>		22e. LOCATION (City, town, or county) <i>Berlin</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>May B. Dennis</i>		240. REC'D. BY REGISTRAR FEB 24 1959 DATE	
ADDRESS <i>Snow Hill, MD</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

STATE OF CALIFORNIA
CENSUS OF 1850

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FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

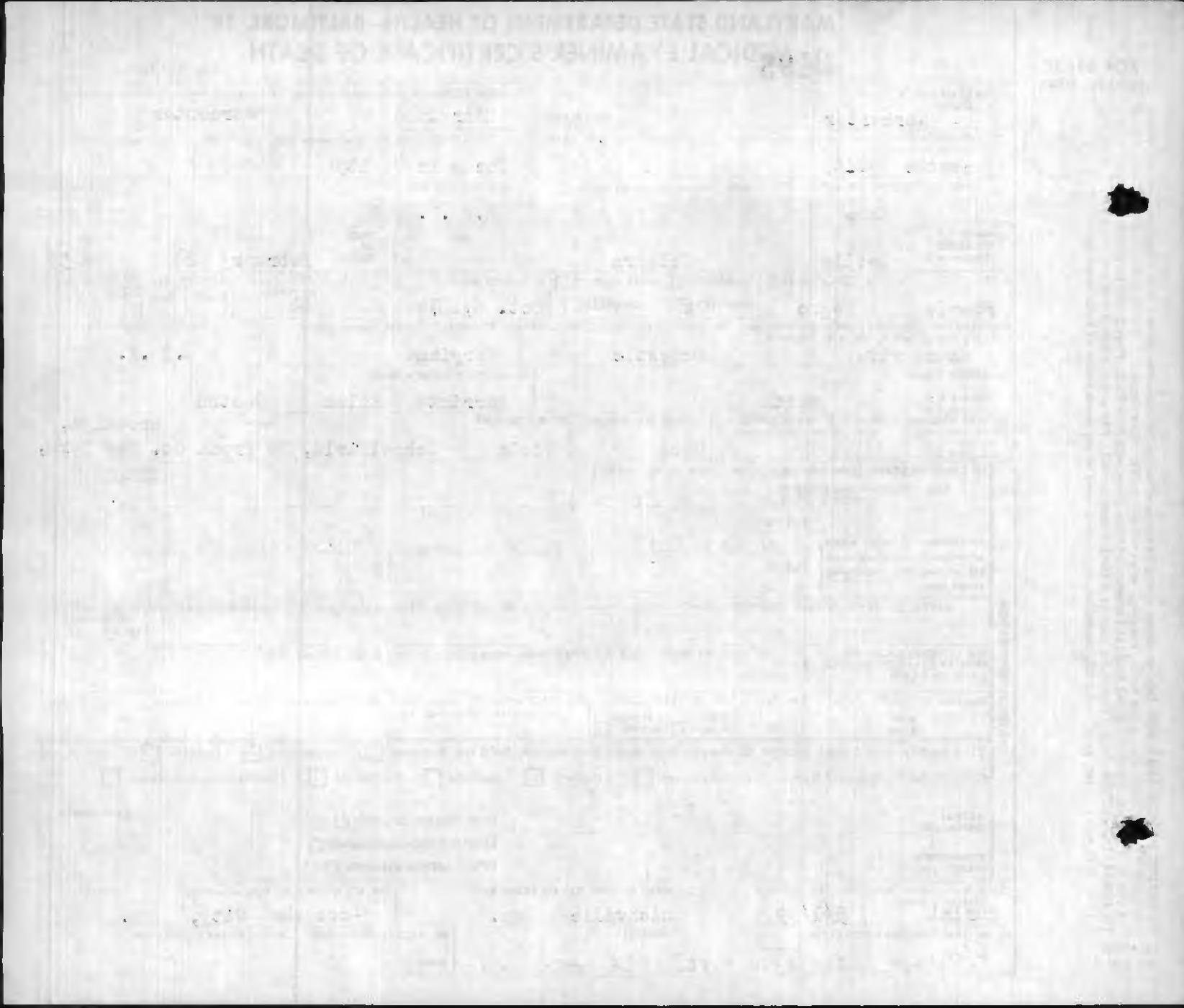
02487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 100 life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pocomoke City	
3. NAME OF DECEASED (Type or print) Amelia		First Colburn	Middle Last
4. DATE OF DEATH R.F. D.O. # 2	Month February	Day 24	Year 19 59
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1874
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Harriett Ellen Goston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT None		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) DUE TO (b) <i>Cardio - Vasculair disease</i> (c) <i>Chronic disease</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Insistant (?)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>N. E. Sartorius, Sr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius</i>		DATE SIGNED <i>2/25/59</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/59	
22c. NAME OF CEMETERY OR CREMATORIAL Unionville Cem.		22d. LOCATION (City, town, or county) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - New Church, Va.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 2 '59
		24b. REGISTRAR'S SIGNATURE <i>Other S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2498

CERTIFICATE OF DEATH

Reg. Dist. No. 02488

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. LENGTH OF STAY IN 1b RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 9th St.				
3. NAME OF DECEASED (Type or print) RUTH WILLETT KUBIT		4. DATE OF DEATH Feb. 4 1959	Month Day Year			
5. SEX F	6. COLOR OR RACE WV	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11 1876			
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) PARKERS LICK Vt			
13. FATHER'S NAME JOHN WILLETT		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Mr. Joseph W. KUBIT, OCEAN CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Occlusive		INTERVAL BETWEEN ONSET AND DEATH 5 days				
(c) Coronary Sclerosis		5:20				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Recess Oct 1958	20f. (City or town) OCEAN CITY, MD	(County) OCEAN	(State) MD
21. I certify that I attended the deceased from 30 Jan 1959 to 4 Feb 1959 , that I last saw the deceased alive on 4 Feb 1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) OCEAN CITY, MD		DATE SIGNED 2/6/59		
ACTUAL SIGNATURE John W. Kubit		M.D.				
PHYSICIAN'S NAME (Type) John W. Kubit						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/6/59	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN	(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna D. Burbage Berlin		ADDRESS Berlin	24a. REC'D BY REGISTRAR Arthur L. Knobell	24b. REGISTRAR'S SIGNATURE Arthur L. Knobell	DATE FEB 9 '59	

81. STATEMENT-REFUSAL TO TESTIMONY STATE OF ALASKA

STATE TO STATE

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2499

CERTIFICATE OF DEATH

Reg. Dist. No.

02489

1. PLACE OF DEATH a. COUNTY WORCESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.		b. COUNTY WORCESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		d. STREET ADDRESS R.F.D.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle SOSIUS	Last QUILLEN	4. DATE OF DEATH FEB. 15 1959	Month FEB.	Day 15	Year 1959
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUN 28, 1886	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ALBERT J. QUILLEN		14. MOTHER'S MAIDEN NAME LOUISE JONES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		
17. INFORMANT Mrs. W. J. QUILLEN, BERLIN MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Pulmonary Edema & Anasarca DUE TO Chronic Regn. Myocarditis & R. Failure 8 mo (c) Chronic Bronchiectasis Bilateral 17 yrs		19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Afteriosclerosis Generalized & Central Nervous		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1947 , 19, to Feb 15 , 1959, that I last saw the deceased alive on Feb 15 , 1959, and that death occurred at 3 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bladensburg		DATE SIGNED				
ACTUAL SIGNATURE Harriet A. Robins		PHYSICIAN'S NAME (Type) Bladensburg		22d. LOCATION (City, town, or county) BERLIN		(State) MD.		
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22f. DATE THEREOF 2/18/59		22g. NAME OF CEMETERY OR CREMATORIAL BUCKINGHAM		22h. LOCATION (City, town, or county) BERLIN		
23. FUNERAL DIRECTOR'S SIGNATURE Anna R. Burbage		ADDRESS Berlin Md		24a. REC'D BY REGISTRAR FEB 24 '59		24b. REGISTRAR'S SIGNATURE John S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
CITY OF SACRAMENTO

DEPARTMENT OF MOTOR VEHICLES

REGISTRATION

EXPIRATION

STATE OF CALIFORNIA
CITY OF SACRAMENTO

DEPARTMENT OF MOTOR VEHICLES

REGISTRATION

EXPIRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 film G239 3-6-59 et
2496 CERTIFICATE OF DEATH

Reg. Dist. No. 102490

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		d. STREET ADDRESS R.F.D. # 2 Box 223		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First Schoolfield	Middle , Jr.	Last	4. DATE OF DEATH February 25	Month 1959	Day Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 59 80 yrs.	IF UNDER 1 YEAR Months 0 D 0 H 0 M.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Schoolfield, Sr.		14. MOTHER'S MAIDEN NAME Susian Boston						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raymond Schoolfield, Pocomoke City, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke, total - secondary to 2 2-3 months DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized, severe - years DUE TO (c) Senile Psychosis, secondary to 2 above. 6 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 19 to Feb. 24, 1959 that I last saw the deceased alive on Feb. 24, 1959 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pocomoke City, Maryland								
ACTUAL SIGNATURE <i>N.E. Sartorius, Jr.</i>		DATE SIGNED DATE SIGNED						
PHYSICIAN'S NAME (Type) N.E. Sartorius, Jr., M.D.		Pocomoke City, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/59		22c. NAME OF CEMETERY OR CREMATORIUM Unionville Cem.		22d. LOCATION (City, town, or county) Pocomoke City, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton - new church, etc.</i>		ADDRESS		24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knob</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2025 RELEASE UNDER E.O. 14176

TRANSIT STATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 9, 11-13, 23, 24-29 et

Reg. Dist. No. 12451

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Worcester City

c. LENGTH OF STAY IN 1b

4 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE

Md.

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Pocomoke City, Md.

d. STREET ADDRESS

R.D.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

Noah

First

Middle

Last

4. DATE
OF
DEATH

Feb 15

Month

Day

Year
1959

5. SEX

M.

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec 24-1921

9. AGE (In years
at time of death)

37 yrs

37 yrs

10. IF UNDER 1 YEAR

Mon. 1

11. IF UNDER 24 HRS.

Days 0

Hours 0

Min. 0

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Agriculture

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Noah Schoofield

14. MOTHER'S MAIDEN NAME

Cecie Francis Czopper

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown. If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

225-28-4638

17. RIFERMA

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)4
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Coronary disease

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

REMOVAL (Specify)

Burial

DATE THEREOF

2-18-59

22b. NAME OF CEMETERY OR CREMATORI

St. James

23. FUNERAL DIRECTOR'S SIGNATURE

Edgar Wharton - New Church, Va.

ADDRESS

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

2/15/59

22d. LOCATION (City, town, or county)

Pocomoke, Md.

(State)

24a. REC'D BY REGISTRAR

FEB 27 '59

DATE

24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112452

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH D. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
WORCESTER MARYLAND		D. STATE Md b. COUNTY WORCESTER	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City (RURAL)		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HERRING CREEK ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City	
3. NAME OF DECEASED (Type or print) EMMA KATHERINE TAYLOR		d. STREET ADDRESS HERRING CREEK ROAD	
4. DATE OF DEATH Feb Month 1 Day Year 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH JAN 18 1882	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Ocean City, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Lewis		14. MOTHER'S MAIDEN NAME Sallie Rayne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-28-2888 17. INFORMANT MRS. EARL Pierree Address Ocean City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion Acute DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE F. J. TOWNSEND, JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED Feb 9, 59			
22a. BURIAL, CREMATION, REMOVAL (specify) 2/10/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL EVANERSON		22d. LOCATION (City, town, or county) BERLIN MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anne A. Bubage Berlin Md		24a. REC'D BY REGISTRAR FEB 11 '59 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2502

CERTIFICATE OF DEATH

Reg. Dist. No. 12493

1. PLACE OF DEATH a. COUNTY <i>Norchester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Whaleyville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Whaleyville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John G. Tull</i>		4. DATE OF DEATH <i>Feb. 25 1959</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 3, 1876</i>
9. AGE (In years lost birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Levin Tull</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Godfrey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>2</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Rada Tull Long - Seabrook</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i></i>	
		Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH <i>0-3 days</i>	
		(b) DUE TO Hypertensive cardio-vascular disease <i>5-10 yrs</i>	
		(c) Atherosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 25, 1959</i> , to <i>Feb. 25, 1959</i> , that I last saw the deceased alive on <i>Feb. 25, 1959</i> , and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Bay St.</i>	
ACTUAL SIGNATURE <i>Robert A. Grubb</i>		DATE SIGNED <i>2/27/59</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT A. GRUBB, M.D.</i>			
22a. BURIAL, CREMATION, REMOVE (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 28, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i>		22d. LOCATION (City, town, or county) <i>Whaleyville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry N. Watson</i>		24e. ADDRESS <i>Paconoke City, Md.</i>	
		24f. REC'D BY REGISTRAR DATE <i>Mar 2 '59</i>	
		24g. REGISTRAR'S SIGNATURE <i>John S. Tull</i>	

CERTIFICATE OF DEATH